LEARNING NEEDS SCREENING

Directions for County Worker

1. Before asking the questions on this form, give the client Form WTW 19 *(Learning Needs Screening - Client Copy)* so he or she can read the questions silently as you read them aloud.

2. Before proceeding to the Learning Needs Screening questions on the following pages, read this statement aloud to the client:

   "We are going to ask you questions about your school experiences and your health. Your answers will help us figure out if anything is getting in your way with training and working. Your answers will also help you and your worker develop your Welfare-to-Work plan and decide what services you will need to be successfully employed. It is very important that you answer these questions so that you can be placed in the right kind of Welfare-to-Work activities and get the help and services you may need to succeed."

3. REFUSAL TO BE SCREENED OR EVALUATED: If the client does not want to be screened, read Form WTW 17 (Waiver of CalWORKs Learning Disabilities Screening and/or Evaluation) to the client and explain the importance of a learning disabilities screening and evaluation. Explain to the client the benefits of a screening and evaluation for learning disabilities. If the client still does not want to be screened or evaluated, have the client sign the form. Give a copy of the form to the client and retain the original in the case file.

4. Ask each of the background questions on page 2.

5. Ask the client each question in sections I, II, III, and IV on page 3.

   a. Record the client's responses by checking "YES" or "NO."

   b. Count the number of "YES" responses in each section, then multiply by the number indicted in the section. For example, multiply the number of "YES" responses obtained in Section III by 3. Then enter the result after the equal sign as the subtotal.

   c. To obtain a total, add the subtotals from sections I, II, III and IV.

   d. If the total from sections I, II, III, and IV is 12 or more, refer the client for learning disabilities evaluation as soon as administratively feasible.

6. Ask the client each of the supplemental questions on page 4.

   a. Record the client's responses by checking "YES" or "NO" and filling in the blanks, where appropriate.

   b. Ask the client to provide any record of previous learning disabilities evaluation, attendance in special education, or medical conditions. If the client appears to have problems obtaining the information, the county will assist the client.

   c. With the client's written consent (WTW 20), forward the records to the learning disabilities evaluator for consideration.

   d. Refer the client, as appropriate, to a medical or service provider(s) to address any potential health concerns identified on this page.

Note: The Learning Needs Screening tool is not intended to determine the existence of a learning disability. It is only the first step in the evaluation process.

LEARNING NEEDS SCREENING

INTERVIEWER NAME

INTERVIEW DATE

BACKGROUND INFORMATION

CLIENT NAME

BIRTH DATE

SEX

☐ MALE ☐ FEMALE

COUNTY

SOCIAL SECURITY NUMBER

COUNTY CASE NUMBER

HIGHEST GRADE COMPLETED (K THROUGH 18)

HIGHEST LEVEL OF SCHOOLING, INCLUDING CERTIFICATED PROGRAMS, TRAINING APPRENTICESHIPS, ETC. *(Check all that apply)*:

☐ HIGH SCHOOL DIPLOMA ☐ GED ☐ TECHNICAL/VOCATIONAL ☐ AA DEGREE ☐ OTHER *(SPECIFY)*:_____

WHAT KIND OF JOB WOULD YOU LIKE TO GET?

HAVE YOU WORKED IN THIS FIELD OR A RELATED FIELD?

WHAT MAKES IT HARD FOR YOU TO GET OR KEEP THIS KIND OF JOB (OR ANY JOB)?

WHAT WOULD HELP YOU FIND OR KEEP A JOB?

LEARNING NEEDS SCREENING

SECTION I	YES	NO
1. Have you had any problems learning in middle school or junior high?	☐	☐
2. Do you have difficulty working from a test booklet to an answer sheet?	☐	☐
3. Do you have difficulty or experience problems working with numbers in a column?	☐	☐
4. Do you have trouble judging distances?	☐	☐
5. Do any family members have learning problems?	☐	☐

Count the number of "YES" answers for Section I _____ X 1 = __0__ Subtotal for Section I

SECTION II	YES	NO
6. Have you had any problems learning in elementary school?	☐	☐
7. Do you have difficulty or experience problems mixing mathematical signs (+/x)?	☐	☐

Count the number of "YES" answers for Section II _____ X 2 = __0__ Subtotal for Section II

SECTION III	YES	NO
8. Do you have difficulty or experience problems filling out forms?	☐	☐
9. Did you experience difficulty memorizing numbers?	☐	☐
10. Do you have difficulty remembering how to spell simple words you know?	☐	☐

Count the number of "YES" answers for Section III _____ X 3 = __0__ Subtotal for Section III

SECTION IV	YES	NO
11. Do you have difficulty or experience problems taking notes?	☐	☐
12. Do you have trouble adding or subtracting small numbers in your head?	☐	☐
13. Were you ever in a special program or given extra help in school?	☐	☐

Count the number of "YES" answers for Section IV _____ X 4 = __0__ Subtotal for Section IV

If total is 12 or more, refer for further evaluation. _____ TOTAL

LEARNING DISABILITIES SCREENING

EDUCATION:

Were you ever in special education classes in school? . . . . . ☐ YES ☐ NO

Have you ever been diagnosed or told you have Learning Disabilities? . . . . . ☐ YES ☐ NO

If YES, by whom?_____ When?_____

Have you ever been diagnosed or told that you have Attention Deficit Disorder with or without hyperactivity? . . . . . ☐ YES ☐ NO

If YES, by whom?_____ When?_____

GLASSES:

Do you need or wear glasses? . . . . . ☐ YES ☐ NO

Was your last vision test within the last two years? . . . . . ☐ YES ☐ NO

HEARING:

Do you need or wear a hearing aid? . . . . . ☐ YES ☐ NO

Have you had your hearing tested in the last 12 months? . . . . . ☐ YES ☐ NO

SPEECH:

Have you ever seen a speech or language therapist? . . . . . ☐ YES ☐ NO

MEDICAL/PHYSICAL:

Have you ever had any of the following:

- a lot of ear infections . . . . . ☐ YES ☐ NO
- a lot of sinus problems . . . . . ☐ YES ☐ NO
- high fevers that lasted a long time . . . . . ☐ YES ☐ NO
- diabetes (high blood sugar) . . . . . ☐ YES ☐ NO
- severe allergies . . . . . ☐ YES ☐ NO
- a lot of headaches or migraines . . . . . ☐ YES ☐ NO
- a head injury . . . . . ☐ YES ☐ NO
- convulsions or seizures . . . . . ☐ YES ☐ NO
- serious health problems . . . . . ☐ YES ☐ NO

Are you taking any medications that affect the way you think, act or feel? . . . . . ☐ YES ☐ NO

If YES, what are you taking?_____

How often?_____

Do you need medical or follow-up services? . . . . . ☐ YES ☐ NO

County referrals needed/made:_____